DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVE	Y
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
	155219	B. WIN	G		09/06/2011	
NAME OF PROVIDER OR SUPPLIE	ER	<u> </u>	1	ADDRESS, CITY, STATE, ZIP CODE NORTH IRONWOOD ROAD		
KINDRED TRANSITIONAL	CARE AND REHAB-SOUTH BEN	D	1	BEND, IN46635		
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
· · · · · · · · · · · · · · · · · · ·	ENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Έ	PLETION
	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000						
		FC	1000	The facility requests that this	nlan	
.	for Investigation of	FC	0000	of correction be considered in		
1 ^	0095949, Complaint			credible allegations of	·	
IN00095249, at	nd Complaint IN00094826.			compliance. Submission of the	nis	
				response and Plan of Correc		
Complaint IN0	0095949 -Substantiated,			is not a legal admission that	a	
Federal/State de	eficiencies related to the			deficiency exists or that this		
	cited at F-241 and F-312.			statement of deficiency was		
unegations are	office at 1 2 11 and 1 312.			correctly cited and is also no		
Compleint Dio	0005240 Sahatantiatad Na			be construed as an admissio	I .	
	0095249-Substantiated, No			interest against the facility, th		
	ated to the allegations are			Administrator, or any employ agents, or other individuals v	I	
cited.				draft or may be discussed in	I	
				response and Plan of Correct	I	
Complaint IN0	0094826-Substantiated,			In addition, preparation and		
Federal/State de	eficiencies related to the			submission of the Plan of		
allegations are	cited at F-241 and F-312.			Correction does not constitut	I .	
				admission or agreement of a		
Survey dates: 9	September 01, 02 and 06,			kind by the facility of the truth	of	
1	september 01, 02 and 00,			any facts alleged or the		
2011				corrections of a conclusions forth in this allegation by the	sei	
				survey agency. Accordingly,	the	
Facility number				facility has prepared and		
Provider number	er: 155219			submitted this Plan of Correc	tion	
AIM number:	100266730			prior to the resolution of appe	eal of	
				this matter solely because of		
Survey team:				requirements under State an	d	
Antoinette Kral	kowski RN			Federal law that mandates		
Time mette Thus	Now, Tel			submission of the Plan of Corrections a condition to		
Census bed typ	۵٠			participate in the Title 18 and	ı Title	
SNF/NF: 110	C.			19 programs. The submission		
				Plan of Correction within this		
Total: 110				timeframe should in no way l	I .	
	Census payor type:			non-compliance or admission	I	
Census payor ty				the facility. Kindred Transition	nal	
Medicare: 21				Care and Rehabilitation-Sout	h	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TD4R11

Facility ID:

000124

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	LE CON		(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		155219	B. WING			09/06/2	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
KINDREI	TRANSITIONAL (CARE AND REHAB-SOUTH BEND			ORTH IRONWOOD ROAD BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFI	ıv	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	Medicaid: 67				Bend respectfully requests a	desk	
	Other: 22				review for the cited deficience		
	Total: 110						
	101.110						
	Sample: 9						
	Supplemental Sa	mnle: 3					
	Supplemental Sa	imple. 3					
	These deficiencie	es also reflect State					
		accordance with 410 IAC					
	16.2.	decordance with 410 II to					
	10.2.						
	Quality review co	ompleted on September					
	12, 2011 by Bev	• •					
	12, 2011 by BCV	radikiler, Kiv					
F0241	•	romote care for residents in					
SS=E		n environment that					
		nces each resident's dignity recognition of his or her					
	individuality.						
	Based on intervie	ew and record review, the	F0241		F 241 Dignity It is the practic	e of	10/06/2011
	facility failed to	ensure the dignity of			this facility to ensure the high		
		nored related to the			quality of care is afforded our residents. Consistent with the		
	prompt answerin	g of call light and timely			practice, the following has be		
		eting care and medication			done: 1. Per Surveyor repor		
	•	meet their needs. This			cited residents' needs had be	een	
		e affected 3 of 3 residents			met by the time of interview.		
		he sample of 9 and 2 of			All residents requiring assists have the potential to be affect		
		_			All interviewable residents wi		
I .	3 residents (#M, #N) in the supplemental sample of 3 reviewed for dignity issues.				interviewed R/T timeliness of		
	Sample of 5 levi	ened for dignity issues.			in meeting his/her needs. The	е	
					grievance process will be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPI	ETED
		155219	B. WIN		-	09/06/2	011
			D. 11111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			NORTH IRONWOOD ROAD		
KINDREI	D TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D	1	I BEND, IN46635		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	:			followed for concerns raised		
					Nursing staff will be inservice		
	1 Resident #B's	clinical record was			customer service, specifical		
		5/11 at 4:30 P.M., and			response to call lights. Staff Angels will interview approp		
		ses of, but not limited to,			residents weekly R/T timeling		
	1	e 5 renal failure, and			of staff in meeting his/her ne		
	1 ' '	· · · · · · · · · · · · · · · · · · ·			weekly X 3 months then qua		
	1 *	nt #B was identified as			thereafter. The grievance pr		
		d and interviewable by			will be followed for concerns		
		initial tour of the unit on			raised. 4. Department head		
	9/01/11 at 11:45	A.M.			audit call light response 5x/v covering all 3 shifts X 3 mor		
					then quarterly with results	11113	
	During interview	with Resident #B on			forwarded to the Performan	ce	
	9/01/11 at 6:15 F	P.M., she indicated she			Improvement Committee for		
		t on and almost always			tracking and trending month	-	
	1 -	f hour or longer. "I've had			months then quarterly there	after.	
		none and call the nurse's					
		p. I need two people to					
	_						
	1 ^	dpan, but there isn't					
		nd one person can't do it.					
	I	over here because I was					
	supposed to get l	better care, but I've never					
	been treated so p	oorly."					
	Resident #B was	interviewed a second					
	time on 9/06/11	at 4:25 P.M., and					
		d soiled her bed because					
		ond to her call light. "I					
	_	no one came to answer					
		ad an accident in my bed.					
	1						
		call light on at 9:00 A.M.,					
		until 10:00 A.M. Two					
		ne crying and went and					
		When I cry out for help					
	they get upset w	ith me, but when they					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155219	B. WIN			09/06/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	D TO A NOITION AL (SADE AND DELIAD COLITILIDEN	n	1	NORTH IRONWOOD ROAD		
	D TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D	SOUTH	BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	IAG	Dia relative 17		DATE
		r call light, what are you					
	supposed to do?'						
	A "Comprehensi	ve Care Plan Report,"					
	1 ^	dicated, "Problem:					
	· ·	eeds bed pan to remain					
	l ` ′	rel and bladderGoal:					
		nain continent of B/B					
	,	der) with use of bed Assist resident on the bed					
		sts. Allow resident time					
	_	n. return when she puts					
	_						
	on her call light	····					
	A "Comprehensi	ve Care Plan Report,"					
	1 ^	d updated 8/18/11,					
		•					
		oach: (Resident #B) has a					
		alling other units with					
	1 -	Also calls out for nurse					
	1 * * * * *	pposed to using the call					
	-	dent will have decreased					
	1 -	lling other units for					
		resident will have					
		les of calling out for the					
	nurse, will use ca	an ngnt pproach: Staff will					
	address resident's	• •					
		•					
		wering call light q (every)					
	shift in an appro	priate manner					
	2 Resident #Dla	clinical record was					
		5/11 at 5:15 P.M., and					
	_	ses of, but not limited to,					
	acute tenai injur	y, history of UTI (urinary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155219	B. WIN			09/06/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			NORTH IRONWOOD ROAD		
KINDRE	D TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D	1	BEND, IN46635		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	tract infection),	and morbid obesity.					
	Resident #D was	s identified as alert and					
	oriented and inte	erviewable by RN #2					
		our of the unit on 9/01/11					
	at 11:45 A.M.	011 01 4110 41111 011 37 0 17 1 1					
	dt 11.45 / t.ivi.						
	D., min a :4	ion with Doridant #D					
		riew with Resident #D on					
		P.M., she indicated it has					
		our to get assistance. "I					
	1	on and no one came. I'm					
		say it, but I pooped my					
	bed. Yesterday v	when I had my accident, it					
	was over a half l	nour wait. I have an open					
	wound and I wo	rry about stool getting					
	into it."						
	Resident #D's "O	Comprehensive Care					
	Plan," dated 8/20	0/11, indicated, "Problem:					
	1 '	at risk for UTI (urinary					
	, ,	R/T (related to) hx					
	1	sApproach:offer to					
	toilet, peri care f						
		or meonunciit					
	episodes"						
	2 Danisland HT!	-1i-i11					
		clinical record was					
	1	6/11 at 3:25 P.M., and					
	_	ses of, but not limited to,					
	1	oma, depression, and					
	fractured right a	nkle. Resident #L was					
	identified as alea	t and oriented and					
	interviewable by	RN#2 while on initial					
	1	on 9/01/11 at 11:45 A.M.					
	During an interv	riew with Resident #L on					

000124

STATEMEN	T OF DEFICIENCIES	CIENCIES X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPL	ETED
		155219	B. WIN			09/06/2	011
			P. (12)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	-		1	NORTH IRONWOOD ROAD		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-SOUTH BEN	1D	1	BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		.M., she indicated her					
	call light is not a	•					
	promptly. She we	ent on to explain she had					
	her call light on t	for one and a half hours					
	earlier in that mo	rning to request a pain					
	pill prior to havir	ng physical therapy. "My					
		one hour before anyone					
	1 -	waited another half an					
		get the medication." She					
		scomfort as a result of the					
	delay.	scomfort as a result of the					
	delay.						
ı	Review of Physic	cian's Orders indicated					
	1	ived Duragesic (a					
		dication patch worn					
		g. (micrograms) every 72					
		(oral narcotic pain					
		•					
	1	25 mg. (milligrams) PO					
	I '	r times a day) PRN (as					
	needed).						
	1 Resident #M	was identified as alert					
		interviewable by RN #2					
		our of the unit on 9/01/11					
	at 11:45 A.M.						
	During an intervi	iew with Resident #M on					
	_	M., he indicated he had					
		els (exact date not					
	•	t by the time someone					
	_	call light, he had soiled					
		two people to assist me.					
		yself, I would. I know					
	they are busy and	d have others to take care					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPI	LETED
		155219	B. WIN			09/06/2	011
			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	S.		1	NORTH IRONWOOD ROAD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D	1	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	of."						
	5. Resident #N w	vas identified as alert and					
	oriented and inte	rviewable by RN #2					
		our of the unit on 9/01/11					
	at 11:45 A.M.						
	αι 11. 7 3 Λ.ΨΙ.						
	D	in the Deviation //NL on					
	_	iew with Resident #N on					
		P.M., she indicated she					
		inutes earlier that					
	morning for her	call light to be answered.					
	"I can toilet myse	elf; I just needed some ice					
	water. I try to do	as much for myself as I					
	can."	-					
	LPN #4 was inte	rviewed on 9/06/11 at					
		ndicated she generally has					
		o provide care for. "It					
		ery often, but a nurse					
	_	so we are short-handed.					
	"I've had to pick	up an extra 10 residents					
	today."						
	Social Service St	taff #3 was interviewed					
	on 9/06/11 at 4:5	5 P.M., and indicated he					
		of complaints regarding					
	_	We have several residents					
	_	we do have numerous,					
		-					
		ents that require two					
	people assist."						
	This Federal tag	relates to complaint					
	IN00094826 and	IN00095949.					

000124

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155219	B. WING			09/06/20	011
KINDRE		CARE AND REHAB-SOUTH BEND		52654 N SOUTH	DDRESS, CITY, STATE, ZIP CODE IORTH IRONWOOD ROAD BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION
F0312 SS=E	A resident who is a of daily living receit to maintain good repersonal and oral Based on intervier facility failed to present to maintain good repersonal and oral Based on intervier facility failed to present the sample of 9 at #O) in the supple residents reviewed on staff for care at Findings include 1. Resident #B's reviewed on 9/06 indicated diagnost depression, Stage obesity. Resident alert and oriented RN #2 while on it 9/01/11 at 11:45. During interviewed 9/01/11 at 6:15 Preputs her call light	ew and record review, the provide for the toileting residents (#B, #D, #K) in and 2 of 3 residents (#M, emental sample of 3 ed who were dependent and assistance. : clinical record was 6/11 at 4:30 P.M., and sees of, but not limited to, e 5 renal failure, and the B was identified as d and interviewable by initial tour of the unit on	F0	312	F 312 ADL Assistance It is the practice of this facility to ensit the highest quality of care is afforded our residents. Consistent with this practice, following has been done: 1. Surveyor report, the cited residents' needs had been must the time of interview. 2. All residents requiring assistanch have the potential to be affect All interviewable residents with interviewed R/T timeliness of in meeting his/her needs. The grievance process will be followed for concerns raised. Nursing staff will be inservice customer service, specifically response to call lights. Staff Angels will interview appropring residents weekly R/T timeline of staff in meeting his/her new weekly X 3 months then qualithereafter. The grievance prowill be followed for concerns raised. 4. Department heads audit call light response 5x/w covering all 3 shifts X 3 months.	the Per let by e cted. ill be f staff e 3. ed on y on liate less eds rterly ocess s will ek	10/06/2011
	-						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND FLAN	OF CORRECTION	155219	- 1	LDING	00	09/06/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER				NORTH IRONWOOD ROAD		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-SOUTH BEN	D	1	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		one and call the nurse's		IAG	then quarterly with results		DATE
	, ,	p. I need two people to			forwarded to the Performan	ce	
		dpan, but there isn't			Improvement Committee for		
	-	nd one person can't do it.			tracking and trending month months then quarterly there		
		over here because I was			months then quarterly there	ailei.	
		petter care, but I've never					
	been treated so p						
	р	J.					
	Resident #B was	interviewed a second					
	time on 9/06/11 a	at 4:25 P.M., and					
	indicated she was	s totally dependent on					
	staff for toileting	and had soiled her bed					
	because staff did	not respond to her call					
	light. "I had diarı	rhea on Sunday (9/04/11)					
	and no one came	to answer my light and I					
	had an accident i	n my bed. Today, I put					
	my call light on a	at 9:00 A.M. and no one					
		A.M. Two office staff					
		nd went and got help for					
	_	out for help they get upset					
		en they don't answer your					
	call light, what a	re you supposed to do?"					
	A "Comprehensi	ve Care Plan Report,"					
		dicated, "Problem:					
	· ·	eds bed pan to remain					
		el and bladderGoal:					
		nain continent of B/B					
	(bowel and blade	ler) with use of bed					
	·	Assist resident on the bed					
		sts. Allow resident time					
	_	n. Return when she puts					
	on her call light	"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TD4R11

Facility ID:

000124

If continuation sheet

Page 9 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155219	B. WING	G		09/06/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					NORTH IRONWOOD ROAD		
KINDRE	D TRANSITIONAL (CARE AND REHAB-SOUTH BEND)	SOUTH	I BEND, IN46635		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1 ^	ve Care Plan Report,"					
		d updated 8/18/11,					
		oach: (resident #B) has a					
	1 ` • • •	alling other units with					
	_	Also calls out for nurse					
		opposed to using the call					
	1 ~	dent will have decreased					
	1 -	lling other units for					
	1	resident will have					
	1	les of calling out for the					
	nurse, will use ca	_					
		approach: Staff will					
	address resident's						
		wering call light q (every)					
	shift in an appro	priate manner"					
	2. Resident #D's	clinical record was					
		6/11 at 5:15 P.M., and					
		ses of, but not limited to,					
	1	y, Stage IV decubitus					
		UTI (urinary tract					
	1 '	norbid obesity. Resident					
	/ /	d as alert and oriented					
		le by RN #2 while on					
		e unit on 9/01/11 at 11:45					
	A.M.	VII // VI/ II W/ II. IV					
	During an interv	iew with Resident #D on					
		P.M., she indicated it has					
		our to get assistance. "I					
		on and no one came. I'm					
	1	ay it, but I pooped my					
		when I had my accident, it					
		nour wait. I have an open					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE		
ANDILAN	or connection	155219		LDING		09/06/2	
		166216	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2	
NAME OF F	PROVIDER OR SUPPLIER				NORTH IRONWOOD ROAD		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-SOUTH BEN	D	1	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		ry about stool getting					
	into it."						
	- · · · · · · · · · · · · · · ·						
		Comprehensive Care					
	·	0/11, indicated, "Problem:					
	` ′	at risk for UTI (urinary					
	· · · · · · · · · · · · · · · · · · ·	/T (related to) hx					
	· · · · · · · · · · · · · · · · · · ·	sApproach:offer to					
	toilet, peri care fo	or incontinent					
	episodes"						
		ent #D's initial MDS					
	`	Set) Assessment, dated					
		d she was continent of					
	bowel and neede	d staff assistance for					
	physical transfer	with a mechanical lift.					
	3. Resident #K's	clinical record was					
	reviewed on 9/06	5/11 at 5:45 P.M. and					
	indicated diagnos	ses of, but not limited to,					
	hypertension, cor	ronary artery disease, and					
	cerebrovascular o	disease.					
	During an intervi	iew with Resident K's					
	spouse on 9/06/1	1 at 3:00 P.M., she					
	indicated she had	l been so upset over the					
	poor response for	r assistance that she					
	documented som	e of her concerns and					
	provided a copy	of her notes. Some of her					
	notations include	ed:					
	"7/17/11 at 7:30.	A.Mlite [sic] on, 7:55					
		ve. say O.K. and leave,					
	` ´	n (still waiting), return					
	8:40 A.M.	<i>5,7</i>					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION OO			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		155219		LDING		09/06/2		
		1.552.15	B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					NORTH IRONWOOD ROAD			
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BENI								
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC1)		DATE	
	_	e] on @ 6:15 P.M., 6:30						
	1 ,	K.' (and leave), arrive						
	· ·	P.Masked to be put back						
		Iaides keep sticking their						
	1	they are coming. Why						
	1	take an hr (hour) to get						
	1 *	11:15 A.M(Resident						
	1 '	n therapy. They (therapy						
	1 ' -	ds to go to the bathroom.						
	1 *	em' (CNA's). 11:42 A.M.						
	-As usual, she (CNA) will get someone.							
	11:50 A.M(CNA) turned lite out-said							
	she would get so	omeone. 11:55 A.MPut						
	in bed, not clean	ed. 12:20 P.Mneeded						
	clean up-(CNA	Name) came 12:30 P.M."						
	Resident #K's sp	ouse further indicated,						
	"We have good i	nsurance. I don't						
	understand why	our insurance company						
	chose this facilit	y for my husband. They						
	do have a good therapy department. I have							
	no complaints about the therapy he gets."							
	A "Comprehensive Care Plan Report,"							
	dated 7/14/11, indicated, "Problem:							
	resident requires assist with ADL's							
	(activities of daily living) R/T weakness							
	and poor mobility	tyApproach: If unable to						
	_	properly-staff to see all						
	ADL's are met d							
		-						
	Review of Resid	lent #K's initial MDS						
	(Minimum Data Set) Assessment, dated							
	7/18/11, indicated he was incontinent of							
	bowel and bladd	er and totally dependent						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	LETED	
		155219	B. WIN			09/06/2	2011	
			D. WII		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	t			NORTH IRONWOOD ROAD			
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND			ND	1	I BEND, IN46635			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		PROPRIATE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	on staff for toilet	ring.						
	4. During an inte	erview with Resident #O's						
	_	on 9/02/11 at 10:00 A.M.,						
		mother needed two staff						
		and sometimes she had to						
	· ·	sn't always worked out for						
	1	inally get her on the						
	· ·	as to wait a long time for						
	someone to come	e back."						
	Resident #O was	s identified as alert and						
	oriented and interviewable by RN #2							
	while on initial tour of the unit on 9/01/11							
	at 11:45 A.M.							
	at 11.43 A.M.							
	7 D 11 / //3.6	:1 .:6 1 1 1						
		was identified as alert and						
		rviewable by RN #2						
while on initial to		our of the unit on 9/01/11						
	at 11:45 A.M.							
	During an interview with Resident #M on							
	_	P.M., he indicated he had						
	to move his bowels (exact date not							
	`							
	remembered), but by the time someone responded to his call light, he had soiled							
	-	_						
	himself. "I need two people to assist me.							
	If I could do it myself, I would. I know							
	they are busy and have others to take care							
	of."							
	LPN #4 was inte	rviewed on 9/06/11 at						
		ndicated she generally has						
		_						
	i 13-20 fesidents t	o provide care for. "It	- 1				I	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	л DI II	A. BUILDING 00		COMPLETED	
155219		B. WIN			09/06/2011		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1	NORTH IRONWOOD ROAD		
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND			D				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X	5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ETION
TAG				TAG	DEFICIENCY)	DAT	Έ
	doesn't happen v	ery often, but a nurse					
	called off today s	so we are short-handed.					
	"I've had to pick	up an extra 10 residents					
	today."						
	Social Service St	taff #3 was interviewed					
		5 P.M., and indicated he					
		of complaints regarding					
	_	We have several (5)					
	_	` '					
	residents in isolation and we do have						
	_	care residents on the 200					
	unit that require	two people assist."					
	D since an intent	to tale at a					
	During an intervi						
		d Nursing Supervisor #5					
	on 9/06/11 at 7:0	0 P.M., they indicated					
	each unit usually	has three nurses and a					
	minimum of five	CNA's on the day shift.					
	Review of the Ni	ursing Schedule for the					
	month of August indicated there were three nurses and five to six CNA's for the day shift, two nurses and five to six						
	CNA's for the evening shift, and two						
	nurses and three to four CNA's on the						
	night shift.						
	Review of a facil	lity roster indicated 64					
		on the 100 unit and 46					
		on the 200 unit. All of					
		oned residents resided on					
	the 200 unit of the facility.						
	_	relates to complaint					
	IN00094826 and	.1N00095949.	1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/06/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND			52654	ADDRESS, CITY, STATE, ZIP CODE NORTH IRONWOOD ROAD I BEND, IN46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-38(a)(3)				